Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMBINED CHIROPRIACTIC SERVICES &
REHABILITATION INC
PO BOX 700311
SAN ANTONIO TX 72870

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-0839

MFDR Date Received
NOVEMBER 14, 2001

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "medical necessity established"

Amount in Dispute: $4,360.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by Continued Chiropractic Hospital for services rendered to [injured worker] for the 07/22/2011 date of service. The bill and documentation attached to the medical dispute have been reviewed and our position remains unchanged. Our rational is as follows: The procedure billed by Carry Davis DC as per the report Dr. Davis performed the technical component and Dr. Edwin Green performed the professional component. The bill was denied CPT 9590059 x 12, 95904 59 x 12, -5903 59 x 8, 95904 x 59 x 2 denied THIS CHARGE APPEARS TO BE FOR TECHNICAL FEE ONLY. APPROPRIATE MODIFIER IS NEEDED TO ACCURATELY REVIEW THIS CHARGE.FOR RECONSIDERATION PLEASE SUBMIT APPEAL WITH EOP AND REQUESTED INFORMAITON. (X055) The provider did not bill the required modifier demonstrating they performed the technical component. This bill was denied for medical necessity. Liberty Mutual believes that Continued Chiropractic has been appropriately reimbursed for services rendered to [injured worker] for the 07/22/2011 dates of service."

Response Submitted by: Liberty Mutual Insurance Group, 2875 Browns Bridge Rd., Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2011	CPT Codes 95900-59 (12 Units); 95903-59 (8 Units); 95904-59 (14 Units); 95864 (1 Unit) and 99211-25 HCPCS Codes A4556; A4215; A4558	$4,360.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization.
4. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
6. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
7. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 1, 2011 and October 19, 2011:

   - 150, X055 – This charge appears to be for technical fee only. Appropriate modifier is needed to accurately review this charge. For reconsideration please submit appeal with EOP and requested information. (X055)
   - 17, X457 – No significant identifiable evaluation and management service has been documented. (X457)
   - D20, B291 – This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed. (B291)
   - X124 – Payment for this charge is not recommended without medical records. For reconsideration please submit appeal with EOP and medical records to support service. (X124)
   - X274 – This provider is not documented as providing the billed service. (X274)
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due. (X598)

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor obtain preauthorization for the services rendered?
3. Did the requestor attached the appropriate modifier when billing?
4. Are the HCPCS codes billed bundled services?
5. Are any of the HCPCS codes billed reimbursable?
6. Is the requestor entitled to reimbursement?

Findings

1. In accordance with §133.307(c)(1)(A) requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. Subparagraph (B)(ii) states that a request may be filed later than one year after the date(s) of service if a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity.
2. In accordance with 28 Texas Administrative Code §134.600(c)The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1)listed in subsection (p) or (q) of this section only when the following situations occur: (A)an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B)preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care; C)concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or (D)when ordered by the Commissioner; or

(2)per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section. Review of the preauthorization approval the treatment/service requested was Electromyography and Nerve Conduction which were approved on July 12, 2011. Therefore, the denial of medical necessity for the EMG and Nerve Conduction is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

The requestor also billed CPT Code 99211-25; office visits do not require preauthorization and the office visit was not one of the services/treatments listed on the preauthorization approval. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Therefore, this code will not be reviewed by Medical Fee Dispute Resolution.

3. Review of the submitted documentation finds that the requestor performed the technical component of the services rendered to the injured employee and attached modifier -59 to the CPT codes billed for the EMG and NCV testing. Modifier -59 is defined as a distinct procedural service. Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. The services provided to the injured worker by the requestor were not considered distinct procedural services. In accordance with 28 Texas Administrative Code 134.203(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits… The insurance carrier denied the services using denial code 150, X055 – "This charge appears to be for technical fee only. Appropriate modifier is needed to accurately review this charge. For reconsideration please submit appeal with EOP and requested information." The requestor requested reconsideration but did not change the modifier. According to Medicare the appropriate modifier for the technical component of the procedure is modifier TC. This modifier identifies the technical component of certain services that combine both the professional and technical portions in one procedure code. Using modifier TC identifies the technical component. Modifier TC is considered a payment modifier and must be reported in the first modifier field. The requestor did not attached modifier TC to the billed EMG and NCV codes; therefore, reimbursement in the amount of $0.00 is recommended.
4. The requestor also billed HCPCS Codes A4556 defined as electrodes, per pair and A4558 – conductive gel or past, for use with electrical device for this date of service. The insurance carrier denied these codes using D20, B291 – "This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed." In accordance with 28 Texas Administrative Code §134.203(b) these codes are considered items or services for which payment is bundled into payment for other the same date of service.
5. The requestor billed HCPCS Code A4215 defined as needle, sterile, any size. In accordance with 28 Texas Administrative Code §134.203(b) (f)For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement). This HCPCS code relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available." The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

6. The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not billed the services in dispute in accordance with Division rules and guidelines or demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.